ATTACHMENT 4

Form Approved:
OMB No. **0920-xxxx**
Exp. Date **xx/xx/2011**

QUESTIONS (In the past 24 hours / hour have you experienced the following:)	1 DAY PRE-COMMUTE	MORNING OF COMMUTE	1 H POST-COMMUTE	2 H POST-COMMUTE	3 H POST-COMMUTE
1. Waking up at night because of breathing difficulties (e.g., cough, wheeze, shortness of breath)?	☐ ☐ yes no	☐ ☐ yes no			
2. Cough?	☐ ☐ yes no	☐ ☐ yes no	☐ ☐ yes no	☐ ☐ yes no	☐ ☐ yes no
3. Wheeze?	☐ ☐ yes no	☐ ☐ yes no	☐ ☐ yes no	☐ ☐ yes no	☐ ☐ yes no
4. Chest tightness?	☐ ☐ yes no	☐ ☐ yes no	☐ ☐ yes no	☐ ☐ yes no	☐ ☐ yes no
5. Shortness of breath?	☐ ☐ yes no	☐ ☐ yes no	☐ ☐ yes no	☐ ☐ yes no	☐ ☐ yes no
6. Chest discomfort or pain?	☐ ☐ yes no	☐ ☐ yes no	☐ ☐ yes no	☐ ☐ yes no	☐ ☐ yes no
7. Palpatations/heart racing?	☐ ☐ yes no	☐ ☐ yes no	☐ ☐ yes no	☐ ☐ yes no	☐ ☐ yes no
8. Numbness/ tingling in arms or neck?	☐ ☐ yes no	☐ ☐ yes no	☐ ☐ yes no	☐ ☐ yes no	☐ ☐ yes no
9. Light headedness/ dizziness?	☐ ☐ yes no	☐ ☐ yes no	☐ ☐ yes no	☐ ☐ yes no	☐ ☐ yes no
10. Other symptom? _____	☐ ☐ yes no	☐ ☐ yes no	☐ ☐ yes no	☐ ☐ yes no	☐ ☐ yes no
11. Other symptom? _____	☐ ☐ yes no	☐ ☐ yes no	☐ ☐ yes no	☐ ☐ yes no	☐ ☐ yes no
12. Medication taken: Name: Dosage:	☐ ☐ yes no	☐ ☐ yes no	☐ ☐ yes no	☐ ☐ yes no	☐ ☐ yes no
13. Medication taken: Name: Dosage:	☐ ☐ yes no	☐ ☐ yes no	☐ ☐ yes no	☐ ☐ yes no	☐ ☐ yes no
14. Medication taken: Name: Dosage:	☐ ☐ yes no	☐ ☐ yes no	☐ ☐ yes no	☐ ☐ yes no	☐ ☐ yes no
15. Did you go to work today?	☐ ☐ yes no	☐ ☐ yes no			
16. Did you spend time outside today?	☐ ☐ yes no	☐ ☐ yes no			
17. Did you spend time cooking and / or cleaning today?	☐ ☐ yes no	☐ ☐ yes no			